STAKEHOLDER INPUT OVERVIEW CARE
REDESIGN PROGRAMS

Maryland's All-Payer Model
Care Redesign Programs – CCIP

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HSCRC
Health Services Cost
Review Commission

Why Are We Embarking on this Initiative?

- GBR model is extremely important to Maryland .To continue to meet the agreement's guardrails more programs should become focused on PAUs.
- Hospitals need Medicare patient specific data for more analysis to target their efforts
- Relief from statutory barriers will allow the hospitals to join forces with other providers and entities
- Increasing the hospitals' reach to be inclusive of primary, hospital – based physicians and post-acute care adds another tool to address the some of the core drivers in PAUs

Purpose of the Amendment

- Maryland has added an Amendment to the All-Payer Model that will provide access to the following **tools**:
  - Detailed, person-centered Medicare data (beyond hospital data across care continuum) for care coordination and care redesign
  - Medicare Total Cost of Care data for planning and monitoring
  - Approvals for sharing resources for care coordination and care improvement
  - Approvals for hospitals to share savings with non-hospital providers

Hospitals gain more options to manage costs.

- Care redesign amendment provides the ability to focus on
  - Coordination among hospitals, physicians, and other providers to provide more person-centered care
  - Strengthened community-based care, including improved complex and chronic care, together with community-based partners
  - Improved episodes of care, from a hospitalization through a post-acute care period
  - Meaningful engagement of patients and families in care decisions
- Hospitals can align efforts and share resources with both hospital and non-hospital providers, ACOs are included

Flexibility of the Amendment

- To provide flexibility, the Amendment is drafted with a framework that aligns categories of care redesign with partners across the delivery system
  - By using a general approach, Maryland can add/delete/modify programs on an annual basis, without requesting the approval of a new model or model amendments
    - New models or amendments can take 6+ months for approval
  - This allows for a "living" approach that can be used to meet Maryland's unique needs on an ongoing basis
    - Programs can be adjusted in response to external changes, such as those introduced by MACRA, Maryland Primary Care Model or other new models
- While the Amendment provides increased flexibility, CMS will:
  - Delegate some administrative functions to the State
  - Retain significant monitoring and oversight responsibilities

Amendment: Care Redesign Programs

- Two initial care redesign programs aim to align hospitals & other providers

Hospital Care Improvement Program (HIP)	Complex and Chronic Care Improvement Program (CCIP)
• **Who?** For hospitals and providers practicing at hospitals	• **Who?** For hospitals and community providers and practitioners
• **What?** Facilitates improvements in hospital care that result in care improvements and efficiency	• **What?** Facilitates high-value activities focused on high needs patients with complex and rising needs, such as multiple chronic conditions • Leverages Medicare Chronic Care Management (CCM) fee*

- Hospitals can select which program(s) to participate in
- Through these voluntary programs, hospitals will be able to obtain data, share resources with providers, and offer optional incentive payments

*Maryland will modify program as needed to adapt to Medicare's MACRA program and the Maryland Primary Care Model

Goals of Care Redesign Programs

Hospital Care Improvement Program

Providers Practicing at Hospitals

- Improve inpatient medical and surgical services delivery
- Facilitate effective transitions of care
- Enhance effective delivery of care during acute care events even beyond hospital walls
- Manage inpatient resources efficiently
- Reduce avoidable utilization with a byproduct of reduced cost per acute care event

Complex and Chronic Care Improvement Program

Community Providers and Practitioners

- Strengthen primary care supports for complex and chronic patients in order to reduce avoidable hospital utilization
- Enhance care management through tools such as effective risk stratification, health risk assessments, and patient-driven care profiles and plans
- Align with Medicare's chronic care management fee (CCM) and potentially other models

Complex and Chronic Care Improvement Program

CCIP is annual with the opportunity to refine each year

- The All-Payer Model Amendment, through which this program is possible, will allow for annual changes to the CCIP.
- As the program is implemented and experienced, adjustments will be made, based on learnings.
- A priority for development is a program that will enhance the relationship between hospitals and the nursing home community.
- Programs will enable hospitals to share resources and to offer incentives within certain guidelines

Major Components of CCIP

- Care Redesign Interventions - defined activities and processes known to treat, reduce and improve the health of chronic and complexly ill Medicare FFS patients.
- Care Redesign Resources -
  - Technology - risk stratification for patient identification, health information technology and meaningful reports with Care Providers.
  - Care Management Resources – including staffing, developed care management processes, protocols and needed ancillary services (i.e. – 24 hour access to care manager) and care plan systems
- Savings – generated from reducing PAUs are used to fund Intervention Resources and may fund incentive payments to Care Providers

CCIP in Brief

- Hospitals use Medicare and other data to identify high and rising risk patients that would benefit from complex and chronic care management.. Medicare and other data is also used to identify the likely "Patient Designated Provider" (PDP) who the patient will affirm to manage their care. PDP signs an agreement with Hospital.
- The Hospital provides Care Redesign Resources to facilitate the care management of the patient participants.
- The PDPs and the Hospital agree to perform defined Care Redesign Interventions to prevent potentially unnecessary hospitalizations and improve quality.
- Results are measured year over year, with PAU savings potentially being used to pay incentives to PDPs.

Overview of Program Structure

- Participation agreements (like all CMS models)
  - Agreements which establish direct relationships between CMS, hospitals, and the State
  - Agreements between a hospital and participating providers
- Implementation protocols
  - Template provided by the State and submitted by hospitals
- Quality/outcomes reporting requirements
- Hospital-specific governance structure, including:
  - A Hospital Oversight Committee – consists of hospital representatives, PDPs and community-based providers (at least 50% membership) and one consumer representative and one Medicare representative
  - Subcommittees representing the Hospital Care Improvement Program and the CCIP if a hospital is participating in both

The Role of the Participating Hospital

- Hospitals will identify patients for the program. Example - The high risk criteria may be patients must have had 3 or more admissions in one year plus a diagnosis of any one or more of the following conditions: CHF, COPD, Diabetes or Hypertension. The rising risk may be the same conditions with 2 admissions and one ED visit in one year.
- All Medicare FFS hospital patients who meet the criteria are eligible – all payers and the uninsured.
- Hospitals will identify the PDP through patient selection, CRISP data, or other methods.
- Hospitals will invite the PDP to participate - sharing program information, metrics, expectations and potential patient list.
- A contract between the hospital and the non-hospital participants must be signed for program participation. The agreement must include:
  - Narrative description of the CCIP
  - Criteria for participation
  - Definition of care management requirements
  - Formula for incentive payment, if applicable
  - Roles and responsibilities of Hospital, PDP, and CRISP

The Role of the Participating Hospital (cont.)

- Electronic health records and care management programs are needed for participation in CCIP. Care management technology may be provided by CRISP or the assigning hospital.
- Hospitals will organize care management resources to handle some care coordination functions to assist the PDP's execution of care management activities including:
  - Follow up of the care plan goals
  - 24/7 access to a care manager
  - Ensure smooth care referrals and follow up on care plan appointments
  - Health education and follow up calls
  - Manage care transitions
  - Ensure connections to needed community resources
- The hospital, CRISP or some other organization will provide quarterly updates on metrics and costs
  - Individual scorecards
  - Updated patient attribution (i.e. patient provider changes)

The Role of the Patient Designated Provider

- PDPs must agree to meet certain criteria in order to be eligible for participation:
  - Provide direction to the care management team provided by the hospital
  - Agree to deploy processes to invite patient participation including agreement (written or verbal) for participation, agreement to electronic communication of medical information to medical partners, how cost sharing works, explanation of care management service, and an explanation of how to revoke the service.
  - Agree to upload CCIP participating patient panels into CRISP including additions and deletions
  - The program requires the use of certified electronic health record technology. Participants must be willing to participate in a hospital's care coordination program or use their own technology provided it meets the EHR certified technology requirements of CMS. If the provider is using their own software, it must be capable of sharing data electronically with CRISP for the purpose of producing metrics and determining the incentive. Key metrics for the program must be recorded in the care management software.
  - Agree to a structured recording of patient health information development and up keep of patient health care management plan.
  - PDP will review the care plan before each office visit
- PDPs may participate in the programs of multiple hospitals

The Role of the Patient Designated Provider (cont.)

- Several activities known to improve the quality of care and reduce costs by avoiding admissions and readmissions will be measured in the CCIP. PDPs must complete a minimum of 80% of the care activities for 80% of the enrolled patients. The measurement will be done on a patient by patient basis. (example included earlier in the deck)
  - Completion of an HRA
  - Active management of the care plan
  - Medication reconciliation
  - 7-14 day PCP post-hospitalization visit
- The required intervention activities may be changed each year. Additional quality indicators may be added to the metrics for additional points depending upon the program's criteria – for example
  - Ace inhibitor and beta blocker therapy when LVEF is < 40
  - Set goals and monitor HgB A1C levels at least quarterly
  - Develop hypertension plan and monitor goals
  - Evidence of pneumonia vaccine and booster within 5 yrs. if patient is eligible

CCIP Incentive Funding and Payouts

Hospitals may elect to provide financial incentives to PDPs in year two. Three interacting goals must be accomplished for financial incentives to be paid:

1. PDPs complete a set of activities known to reduce the need for hospitalizations for each patient in the CCIP:
   - Completion of a Health Risk Assessment (HRA)
   - Completion of a Care Plan
   - Medication management
   - Post-discharge management
2. The incentive pool from which PDPs are paid is funded by actual reductions in avoidable utilization. **The money comes from the hospital budget.**
3. Total Cost of Care (TCOC) "Guardrails" are met in order for incentives to be paid. This ensures that reductions in PAUs are not achieved by shifting care/costs to other settings such as post-acute care.

1. **PDPs complete a set of activities** known to reduce the need for hospitalizations, for each patient in the CCIP (Illustration follows)

- Activities known to improve the quality of care and reduce the need for admissions and readmissions will be measured in the CCIP. The measurement is done patient by patient - allowing the PDP to earn points for each patient in the program.
- PDPs must complete 80% of the care activities for 80% of the patients to qualify for the incentive.
- After meeting the threshold for the incentive payment, each patient's score is then examined. For all patients who have had 80% or more of the required activities performed, their scores qualify for the bonus calculation. First, a risk adjustment factor will be applied to the patient's score. This factor is intended to compensate the PDP for the intensity of care needed by some patients. A simple risk adjustment computation is used. Hierarchical Condition Categories (HCC) provided by Medicare are used for risk adjustment. If a patient's score is 1.26 or higher, the payment per patient is increased by 50%.

1. **PDPs complete a set of activities** known to reduce the need for hospitalizations, for each patient in the CCIP (Illustration on the next two pages)

- A quality incentive is then applied for activity-completion rates of over 85%. Scores of 85% to 90% are multiplied by 1.05, 90% to 95% are multiplied by 1.10 and scores over 95% are multiplied by 1.15.
- The maximum annual payment per patient is $665 before risk adjustment and quality incentive. The maximum with risk adjustment and full quality incentive is $1,146.55. This compensates the PDP for additional work while ensuring an amount disproportionate to the work is not paid.
- Under some circumstances, a PDP may qualify for a monthly CCM fee ($42 - $99) from Medicare.

1. PDPs Complete a Set of Activities Known to Reduce the need for hospitalizations. **Example**

80% of the enrolled patients must receive 80% of the care activities to qualify for a bonus

A patients score must exceed 80% to qualify for a bonus calculation

If the patient's HCC score is 1.26 or higher , the score is increased by 50%.

Quality Incentive points are added for scores 85% and over.

All of the PDP scores are summed and then divided into the incentive pool to determine the incentive amount.
Example: PDP A Score + PDP B Score+ PDP C Score etc. = Total points.
Incentive Pool /Total Points =Point Value
Each PDP score is then multiplied by the point value to determine the PDP's incentive.

*Note - the top limit on point value is $665

Patient Designated Provider Scoring Calculations

Metrics	Patient 1	Patient 2	Patient 3	Patient 4
For Illustrative purposes only				
Complete HRA	Yes	Yes	Yes	Yes
Care Plan Management	Yes	Yes	Yes	Yes
PDP visit w/in 7dys inpatient stay	Yes	No	Yes	N/A
Pneumonia Vaccine	Yes	Yes	Yes	N/A
Medication Reconciliation	Yes	No	No	Yes
Disease Specific Quality Metric	Yes	Yes	Yes	Yes
Totals	6/6 = 100%	4/6 = 67%	5/6 = 83%	4/4 = 100%
Do patient metrics meet incentive thresholds?	Yes	No	Yes	Yes
Risk Adjustment HCC score .6-1.25 =1, HCC score 1.26+ = 1.5	1*1=1	0*1.5=0	1*1.5=1.5	1*1.5=1.5
Quality Incentive >85% to 90% = 1.05 multiplier >90% to 95% = 1.10 multiplier >95% = 1.15 multiplier	1.15	N/A	N/A	1.15
Total Points per Patient	1.15	0	1.5	1.725
Total Score for Patient Designated Provider = 4.375				

Example of Annual Incentive Opportunity: High-Risk Patients - **Example**

Assume the incentive pool can fund the entire potential incentive. The PDP in this illustration would receive **$665*4.375= $2,909.38 for these four patients.**

Assume that three of the four patients qualify for CCM, the PDP will earn another (($42*12)*3) or **$1,512 paid by CMS.**

In this example the PDP annual total is $4,420.38 for the care of these four patients.

*Note - the top limit on point value is $665

Patient Designated Provider Scoring Calculations

Metrics	Patient 1	Patient 2	Patient 3	Patient 4
For Illustrative purposes only				
Complete HRA	Yes	Yes	Yes	Yes
Care Plan Management	Yes	Yes	Yes	Yes
PDP visit w/in 7dys inpatient stay	Yes	No	Yes	N/A
Pneumonia Vaccine	Yes	Yes	Yes	N/A
Medication Reconciliation	Yes	No	No	Yes
Disease Specific Quality Metric	Yes	Yes	Yes	Yes
Totals	6/6 = 100%	4/6 = 67%	5/6 = 83%	4/4 = 100%
Do patient metrics meet incentive thresholds?	Yes	No	Yes	Yes
Risk Adjustment HCC score .6-1.25 =1, HCC score 1.26+ = 1.5	1*1=1	0*1.5=0	1*1.5=1.5	1*1.5=1.5
Quality Incentive >85% to 90% = 1.05 multiplier >90% to 95% = 1.10 multiplier >95% = 1.15 multiplier	1.15	N/A	N/A	1.15
Total Points per Patient	1.15	0	1.5	1.725
Total Score for Patient Designated Provider				4.375

Detail of Incentives Payments For Rising Risk Patients

- The same activities known to improve the quality of care and reduce costs by avoiding admissions and readmissions will be measured in the CCIP. After the minimum threshold completion of 80% of the care activities received by 80% of the eligible patients, the bonus is calculated patient by patient.
- The maximum payment per patient is $100 before risk adjustment or quality incentive. The maximum with risk adjustment and full quality incentive is $172.50 for one year. This compensates the PDP for additional work while ensuring an amount disproportionate to the work is not paid. See the illustration on the next page.
- Everything else is the same:
  - 80% threshold is used, scores are computed per patient
  - Risk adjustment factors are the same as high-risk
  - Quality incentives are the same as high-risk
  - CCM leverage is the same

Annual Incentive Opportunity: Rising-Risk Patients - **Example**

Assume the incentive pool can fund the entire potential incentive. The PDP in the illustration would receive **$100*4.375= 437.50 from the hospital for these four patients.**

Assume that three of the four patients qualify for CCM, the PDP will earn another (($42*12)*3) or **$1,512 paid by CMS.**

In this example the PDP total is $1949.50 for the care of these four patients.

*Note - the top limit on point value is $100

Patient Designated Provider Scoring Calculations

Metrics	Patient 1	Patient 2	Patient 3	Patient 4
For Illustrative purposes only				
Complete HRA	Yes	Yes	Yes	Yes
Care Plan Management	Yes	Yes	Yes	Yes
PDP visit w/in 7dys inpatient stay	Yes	No	Yes	N/A
Pneumonia Vaccine	Yes	Yes	Yes	N/A
Medication Reconciliation	Yes	No	No	Yes
Disease Specific Quality Metric	Yes	Yes	Yes	Yes
Totals	6/6 = 100%	4/6 = 67%	5/6 = 83%	4/4 = 100%
Do patient metrics meet incentive thresholds?	Yes	No	Yes	Yes
Risk Adjustment HCC score .6-1.25 =1, HCC score 1.26+ = 1.5	1*1=1	0*1.5=0	1*1.5=1.5	1*1.5=1.5
Quality Incentive >85% to 90% = 1.05 multiplier >90% to 95% = 1.10 multiplier >95% = 1.15 multiplier	1.15	N/A	N/A	1.15
Total Points per Patient	1.15	0	1.5	1.725
Total Score for Patient Designated Provider				4.375

2. The **incentive pool** from which PDPs are paid is funded by actual reductions in avoidable utilization

- The CCIP Incentive Pool is derived from the savings driven by reduced avoidable utilization in a specified population.
- The specified population includes all patients in the hospital geography that correspond to the cohort of patients in the CCIP. This creates a larger pool of patients as a basis for pool funding. The purpose is to acknowledge that savings attributable to a specific set of people takes time and to create a situation where money is available to incentivize providers while they are transforming their practices. The hospitals will only fund based on actual reductions in cost.
- The incentive pool is funded by a dollar amount that is the difference between the standardized historical costs of included avoidable utilization in a base year less the standardized costs of actual avoidable costs in the current year, multiplied by a 50% variable cost savings factor, minus the intervention costs.
- The intervention costs are the hospital provided resources such as care management technology and care management staff to enable the care management process.

3. **Total Cost of Care "Guardrails"** are met in order for incentives to be paid

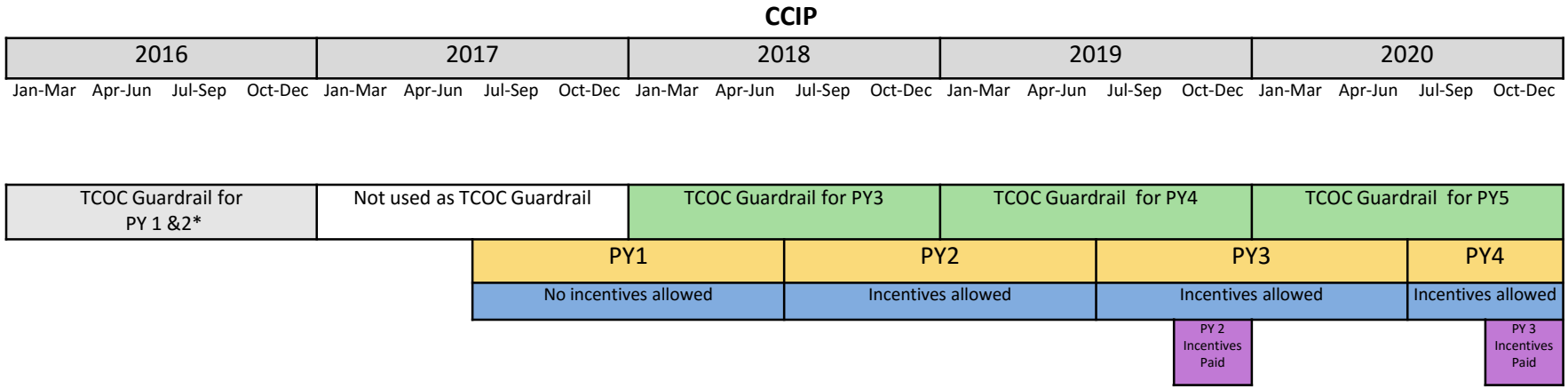
Total Cost of Care

- Total Cost of Care (TCOC) Guardrails are calculated at the hospital level
- Hospitals will be limited or precluded from paying financial incentives to providers if the TCOC for a set of hospital services and geographically determined non-hospital services does not remain below a predetermined benchmark
- If a hospital's care redesign programs increase the TCOC beyond the benchmark or do not meet the quality standards, incentive payments to providers will be limited or may not be allowed at all
- The TCOC Guardrail will ensure that the Medicare Trust Fund and other insurers in Maryland do not support inappropriate cost shifting but instead incentivize providers to engage in activities that benefit patient health, increase quality, and improve outcomes.

Quality

- Hospital Guardrails are calculated at the hospital level.
- If quality targets for the population are not met, then incentives are not paid or are paid at a reduced level

CCIP Calendar



- Performance years coincide with fiscal years (PY1 - July 2017 – June 2018).
- TCOC guardrail and incentive pool calculations coincide with the calendar year prior to the beginning of the performance year (TCOC/Incentive pool for PY1 is calendar year 2016).
- *State-wide TCOC guardrail achieved in 2016 will be used for PYs 1 and 2 so that hospitals/providers have a grace period to monitor/understand hospital specific TCOC while building momentum and relationships with aligned physicians.

What are the Benefits to the Amendment Programs?

Benefits to Patients and Marylanders

- Improved quality of care- in the hospital and in the community
- Person-centered care
- Enhanced coordination of care across the health care delivery system
- Improved care management
- Reduced avoidable hospitalizations
- Population health focus
- Improved patient engagement

Benefits to Hospitals

- Access to detailed Medicare Claims data for care redesign
- Closer alignment with physicians and other community providers, focused on common goals
- Greater savings and reductions of potentially avoidable utilization under global budgets
- Increased quality scores
- Approvals for sharing resources and savings to physicians and other community providers
- Enhanced person-centered focus of care and better outcomes

Benefits to Physicians and Other Community Providers

- Increased access to care management resources
  - Care resources to execute the provider's orders, handle care coordination, and manage care transitions
- Support care management for high risk patients to ensure care plans are being implemented
- Participation in programs can be tailored to support MACRA requirements
- Access to potential incentives from the hospital for performing activities that will improve care, reduce potentially avoidable hospitalization and reduce the total cost of care

Benefits to the All-Payer Model

- Leverage the Amendment to address Medicare Total Cost of Care (TCOC)
  - Not yet taking on full responsibility for TCOC and system-wide outcomes
  - Start receiving TCOC data and other data to support care coordination and chronic care improvements
  - Learn how to utilize data and make delivery system changes that act on the most significant opportunities for care improvement

- Improve care and control costs by focusing on:
  - A person-centered approach in coordination with physicians and other community providers
  - Persons with high needs and chronic conditions
  - Population health
  - Episode costs and outcomes (including post-acute)
  - Alignment of providers around common measures and goals